Transitions
Health Care

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Linda Cole
Chief – Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2254

RE: Comments on COMAR 10.24.08 – Hospice Services

Dear Ms. Cole:

We have provided some initial comments on COMAR 10.24.08, reserving, however, our right to provide additional comments before the end of the public comment period on October 26th. While these comments are directed primarily at hospice services, we also believe there may be a need for additional nursing home beds to accommodate increases in hospice inpatient care.

A stated mission of the Health Care Commission is to create a blueprint that assures that the health care system provides access, choice and quality. The proposed Plan, in its current form, needs to be amended to meet these objectives. The following is a summary of shortcomings in the current version of the Plan that are included in our comments.

1) The methodology used to forecast need in 2010 uses an understated estimate of current need;

2) The annual growth rate used in the projections is lower than CMS and private sector estimates;

3) The Plan does not assure that there will be adequate choice and access; and

4) The Plan does not make Maryland a leader and innovator in hospice care.

1) LOW BASE YEAR ASSUMPTION. The starting point for projecting the system's future hospice needs require an accurate assessment of current needs. The projections in Supplement 2 of the Plan are based entirely on data from the hospice survey report and do not take into account the thousands of Maryland residents who die each year from causes where hospice services are an appropriate, and typically best, end-of-life care option. The current projections do not include those Maryland residents who had a need for hospice services, but were never served by the system and included in the survey data. In a letter sent last May, we urged the Commission to adopt a forecast methodology that independently assessed the current need for hospice services. In this letter we also provided a suggested methodology that assessed need based on the cause death. In Table A, below, there is a ranking of causes of death in Maryland in 2002. This table shows that more than 69% of all deaths were attributable to cancers, heart disease and Alzheimer's, all of which are highly appropriate for hospice care. This table also shows that only 4% of all deaths are from unintentional injury, such a car accident, homicide or suicide. The remaining 27% of deaths were from other causes where, in many situations, patients would be eligible and appropriate for hospice services.

TABLE A

CAUSES OF DEATH IN MARYLAND

Rank	Causes of Death	% of Total
1	Heart Disease	35.7%
2	Malignant Neoplasms	30.9%
3	Cerebrovascular	8.4%
4	Chronic Low. Respiratory Disease	5.8%
5	Diabetes Mellitus	4.5%
6	Unintentional Injury	4.0%
7	Influenza & Pneumonia	3.3%
8	Septicemia	3.0%
9	Alzheimer's Disease	2.6%
10	Nephritis	1.9%
	Total	100.0%

In Table B, below, we then compared the hospice deaths reported in the 2004 survey against three independent estimates of hospice need based on causes of death. These estimates

assumed that between 60 – 70% of terminally ill patients qualified, and were appropriate, for hospice services. This comparison suggests that in the urban counties less than one-third of the hospice needs in these jurisdictions have been served.

TABLE B

HOSPICE SURVEY DEATHS
VERSUS
ESTIMATES BASED ON THE CAUSE OF DEATH

	Survey Data	Percent of All Deaths Where Hospice Care is Appropriate		
	Deaths	@ 60%	@ 65%	@ 70%
Anne Arundel	1,031	2,468	2,673	2,879
Prince George's	946	4,039	4,376	4,712
Baltimore	2,054	3,802	4,118	4,435
Montgomery	1,937	4,402	4,768	5,135

2) LOW GROWTH RATE ASSUMPTION. The Centers for Medicare and Medicaid Services estimates that in FY 2006, Medicare/Medicaid would spend $7.1 billion for hospice services. This is an 87% increase from FY 2004 expenditure levels, or an annual increase in spending of more than 20%. Private sector estimates are that the hospice market basket will continue to grow for the next 5 – 10 years at approximately 10% per annum. The growth assumptions used in the hospice need projections are less than 5%. The Plan's methodology for estimating growth should be upwardly adjusted.

3) DOES NOT ASSURE ACCESS AND CHOICE. The Plan does not address a need for additional programs in those counties where there is only one licensed program. The Plan also does not address the need to assure that the legacy programs will expand their geographic footprint in order to meet the needs of all of the residents in the counties that they are licensed in. In health care systems where there is not a certificate of need requirement, the geographic expansion of hospice services is largely driven by market need and competition. In Maryland and other CON states, geographic expansion must be managed and driven by a state-wide plan to assure that services are available in all markets and available to all residents. Choice is a second area that the Plan does not adequately provide for and there are many markets that are served by a single program. The patient and the patient's family need and deserve choices. In the 2004 survey it was reported that only 4 programs out of 33 had more than a single office location, and

that 29 out of 33 programs were not-for profit organizations. It is our opinion that the Plan need to be modified to assure a sufficiently wide geographic footprint is created and needs to increase the number of licensed programs in order to accomplish this important objective.

4) MARYLAND NOT A LEADER AND INNOVATOR IN HOSPICE SERVICES. In recent years the growth of hospice care services in Maryland has lagged behind many other states. This observation was recently voiced by the Commission's executive director who asked a group of hospice providers last February "why Maryland's position as an early industry leader has slipped". Maryland's aging population and families of terminally-ill patients deserve a health care system that is a leader and innovator in hospice care. The Plan needs to be adjusted if Maryland is to regain its former position of prominence.

5) DISPELLING MYTHS ABOUT HOW COMPETITION WILL DIMINISH QUALITY. The third part of the Commission's mission is quality. It has been suggested by some that the licensing of new hospice providers, especially the for-profit industry leaders, would have an adverse impact on quality of care because it would require the legacy providers to divert financial resources for marketing initiatives. Others have proffered that there are not enough trained staff to go around, especially RNs, and new providers would drain talent. Still others have suggested that any competition for charitable donations would be financial disaster because a large part of the operating budgets of not-for-profit programs are from charitable contributions. These arguments are not grounded in any reality and in fact hospice services have grown the fastest in those states where new competitors are continually entering the market. Any argument that competition will result in financial crisis or a crisis of quality is a myth.

If you have any questions about these comments or wish to discuss these comments in greater detail, I will be pleased to make the time to visit you at your office.

Sincerely,

Edwin C. Hirsch
Chairman

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